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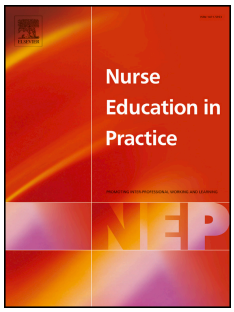

Everywhere and Nowhere: work-based learning in healthcare education

Julie Attenborough, Stephen Abbott, Judy Brook, Rachael-Anne Knight

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List of authors

1. Julie Attenborough

Associate Professor
Associate Dean: Director of Undergraduate Studies
City, University of London
School of Health Sciences
Northampton Square
London
EC1V 0HB
Tel: 020 7040 5313/07885791752
M: j.a.attenborough@city.ac.uk

2. Stephen Abbott

Honorary Senior Research Fellow
City, University of London
School of Health Sciences
Northampton Square
London
EC1V 0HB
E: s.j.abbott@city.ac.uk

3. Judy Brook

Strategic Head of Practice
Senior Lecturer in Health Visiting
City, University of London
School of Health Sciences
Northampton Square
London
EC1V 0HB

E: Judy.brook@city.ac.uk

4. Rachael-Anne Knight

Professor of Phonetics
Associate Dean for Education Excellence and Innovation
City, University of London
School of Health Sciences
Northampton Square
London

EC1V 0HB

E. r.knight-1@city.ac.uk

Everywhere and nowhere: work-based learning in healthcare education

Abstract

The shortage of healthcare professions is a global issue, which has highlighted the need to establish effective practice learning. In 2015 the UK government introduced a change to the way that healthcare education is funded. A subsequent fall in applications to healthcare programmes and high levels of vacancies across the sector in the UK have led to widespread concern about workforce shortages, especially nurses. Subsequently, initiatives that both address the shortage and aim to bridge the gap between registered nurse and healthcare support worker have been introduced, presenting opportunities to further develop the clinical workplace as a learning environment for employees.

A sample of nine healthcare professionals was recruited; seven nurses and two allied health professionals. Semi-structured interviews were conducted between March and June 2018. These were recorded verbatim, transcribed and thematically analysed.

Respondents identified opportunities for work-based learning and factors for success. The importance of an effective learning culture, commitment to work-based learning and time were identified as factors for success. Despite the richness of learning opportunities in healthcare, respondents identified challenges for both learners and supervisors in identifying these opportunities in the workplace. These findings have immediate relevance to healthcare education systems internationally.

Areas for future research include the relationship between supervisor and learner and further insight into why the busiest areas might be identified as more effective learning environments.

Introduction

The nursing workforce is central to the delivery of safe and effective healthcare; concern about global shortages of nurses has put increased emphasis on recruitment, education and retention (Brook et al 2019). As one strategy to address this shortage, the UK government announced in 2015 a radical change to the way that healthcare education is funded in England, moving away from NHS supported programmes to self-funding through student loans. The subsequent fall in applications for healthcare programmes, in the context of high vacancies in qualified staff across the sector and an international shortage of nurses, alongside increasing levels of morbidity in an aging population, has led to widespread concern about the shortage of healthcare professionals in the UK (Buchan et al 2017; Charlesworth et al, 2018; Nuffield Trust 2018).

The introduction of the nursing associate role and apprenticeship levy in 2017, presented new opportunities to address this shortage, and further develop the clinical workplace as a learning environment for employees (Halse et al 2018). The move towards work-based learning (WBL) represents a transition from education that is designed by academic staff and led by higher education institutions, to education delivered in partnership, with increased collaboration between education providers and the clinical environment.

This paper reports on the views and experiences of clinical staff participating in work-based learning, both as supervisors and learners. It forms part of a project funded by Health Education England to identify and address factors in preparing the clinical environment for increased work-based learning.

Work-based learning is not a new concept. Apprenticeship is a long-standing model for vocational training across many work sectors, and nurse education was delivered in an apprenticeship-style employment model until 1995 in the UK. More recently the introduction of a levy charge to fund apprenticeships in the UK has brought new impetus for higher-level, employer-led apprenticeships, with employers inputting to and influencing the curriculum (Major, 2016).

Defining work-based learning

In this paper we use a broad definition of WBL; including both formal and informal aspects, drawing on Eraut's 'continuum of formality' in learning (2004, p 250). At the informal end of the continuum WBL comprises 'implicit, unintended, opportunistic and unstructured learning, with the absence of a teacher'. Practice that is supervised by a mentor or supervisor represents WBL towards the formal end of Eraut's continuum and is also included. The characteristics of WBL encompass consolidation of expertise at work with formal knowledge; learner-managed rather than academic-managed learning, and university educators working in partnership with clinical staff to deliver learning.

This paper discusses WBL in a multidisciplinary clinical workforce comprising medical, nursing and allied health professional learners.

The experience of work-based learning: factors for success

The clinical environment is an established effective and powerful setting for WBL (Liljedahl, 2018), yet the current increase in WBL in healthcare means it is crucial to identify how to best support learners and supervisors in the clinical environment. A number of factors have been identified in the literature.

In a study of the journey of Assistant Practitioners undertaking WBL, Thurgate (2018) identifies effective mentorship and a positive learning culture in the workplace to be key factors for success. Similar factors were identified in Nevalainen et al's (2018) systematic review of qualitative studies reporting on WBL in health care organisations. They identified four factors influencing success: the culture of the workplace, affecting the behaviours of learners and introducing and reinforcing the values of healthcare delivery; the work *space* and how it is organised to promote (or inhibit) learning; the role of managers in enabling and promoting WBL and the interpersonal relationships between the staff in the workplace. Christensen et al (2017) report on the opportunities afforded by WBL compared to classroom or simulated learning in healthcare, and the impact on developing professional identity.

Manley et al (2009) suggest a framework for WBL in healthcare based on concept analysis. Although taking a slightly different approach to the literature above, similar factors for success arise. The framework is divided into enabling factors, attributes (of the learner and the workplace) and the desired outcomes. Overarching enabling factors are identified, firstly, a learning philosophy adopted by the organisation that values a learner-centred approach, negotiated learning outcomes, a positive workplace culture, nurture of reflective and creative practice and collaborative learning promoting partnership working. Secondly Manley et al suggest 'a supportive organisation-wide infrastructure' (p117) with specific structures such as accreditation, locally delivered programmes and identified resources including time allocation and budget support.

The literature provides evidence of enablers and facilitators. In the current context of expanded WBL this paper seeks to clarify whether extant literature sufficiently supports preparation for the workforce in today's context.

Aims of the study

The study sought to explore the experiences of supervisors and learners currently engaged in WBL and is focussed at a point in time, at the introduction of a specific new role in healthcare in the UK and a new initiative to increase access to healthcare education. The study examined learners' and educators' perceptions of opportunities and threats to WBL in the clinical environment; and their perceptions of the factors leading to success in WBL.

Design

Members of a Community of Practice, comprising clinical educators focused on delivering WBL in the locality, were invited to take part in the project. Five respondents agreed to take part, (numbers R1-R5 in Table 1). In order to increase sample size, snowballing was used to recruit four more (numbers R6-R9 in Table 1).

Respondents are listed in Table 1. Role descriptions are generic to provide anonymity to respondents. Respondents were nurses and allied health professionals (radiography and occupational therapy). R8 and R9, though involved in providing WBL in their workplaces, had also recently been students on a nurse prescribing course of which WBL was an integral part. Four local NHS trusts were represented in the study, although these were not purposively sampled by the research team. Apart from R7, respondents were employed in multidisciplinary clinical environments comprising medical, nursing and allied health professionals.

Table 1. Respondents

Semi-structured interviews were carried out with those agreeing to be interviewed. Interviews were based on the topic guide in Box 1. The topic guide was devised in the knowledge that the original sampling frame consisted of health care professionals who had opted into the community of practice thereby demonstrating their enthusiasm for WBL. The approach can therefore be understood as broadly that of appreciative enquiry (Bushe, 2013).

Thematic analysis, as described by Braun and Clarke (2006) was used because of the flexibility of the method in terms of sample size and constitution, research question and data collection method (Braun and Clarke, 2017). Additional benefits of using thematic analysis relate to the accessibility of the method and of the results, the potential to highlight both differences and similarities across the data set and the ability to summarise key features of the data and present the thick description of the data set (Braun and Clarke, 2006). Despite the many advantages of thematic analysis, the flexibility offers potential for inconsistency or lack of coherence when developing themes as the researcher becomes the instrument that analyses the data (Nowell, et al., 2017). This was partially mitigated by the use of three researchers to complete the analysis

The interviews were audio-recorded and transcribed. All three researchers undertook qualitative data analysis, following the six phases of thematic analysis: 1) Familiarisation with the data; 2) Generation of initial codes; 3) Searching for themes; 4) Reviewing themes; 5) Defining and naming themes; and 6) Producing a report (Braun and Clarke, 2006).

All three researchers familiarised themselves with the data, generated codes and initial themes. The three researchers compared and agreed a final set of themes. The themes

emerged from the data, but the authors acknowledge their status as insider-researchers and the challenges and opportunities this brings (Mercer, 2007).

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Approval for the research was given by the **** Research Ethics Committee, at ***** (details removed for anonymity)

Box 1: topic guide

Box 1. Topic guide.

1. Could you describe your involvement with work-based learning?
2. We would like to put together a 'what works' resource. Could you tell me about what is needed to successfully teach in the workplace?
3. Can you give me any examples of how these have successfully been implemented in your workplace?
4. We all know there are lots of constraints but could you give an example of how you have overcome them?
5. Have you ever had a 'lightbulb' moment that changed how you feel about work-based learning?

Findings

What WBL is

The most frequently articulated theme emerging from the data was that WBL is everywhere and nowhere: though it is ubiquitous in clinical settings, it is often unrecognised by learners and teachers.

Respondents identified two categories of learning opportunities; these are divided into primary opportunities- meaning those designed primarily to facilitate learning, and secondary opportunities, where learning is a secondary outcome. The distinction does not denote importance, simply identification (Box 2). These terms differ from Eraut's (2004) 'formal' and 'informal' in that some secondary opportunities are formal occasions designed primarily for other purposes, where individuals may briefly but consciously adopt a teaching role, such as a consultant to junior doctors in a ward round (an example appears in our findings below). Of course, other health care professionals present could also learn from this intervention.

Box 2. Opportunities for WBL

Primary opportunities	*Secondary opportunities*
• written information (e.g. policies and procedures, induction pack) • e-learning • workshops or regular training meetings (including peer teaching) • simulations • working alongside someone more experienced e.g. practice development	• Discussions with colleagues (e.g. meetings, ward rounds, case conferences, safety huddles) • *Ad hoc* discussions • Modelling • Debriefs after serious untoward incidents and near misses • Schwartz rounds • Audits

nurses or clinical nurse specialists • working under supervision • shadowing other staff • visits to other services or teams	• Service development and quality improvement initiatives

Everywhere and nowhere: recognising learning

Primary learning opportunities are mainly self-explanatory, and commonly found in NHS organisations. There were variations between the NHS trusts represented in the research: simulation training was much more developed at T1 than elsewhere, for example, and only some teams have regular training meetings, though those that did valued them highly.

Respondents spoke at greater length of secondary opportunities. The contribution of these to WBL was actually and potentially significant, though this was not always recognised by learners.

> *'People tend to think it's about going on a course and you say, "No, it's reflecting, it's attending a meeting, it's discussing things with colleagues, it's case studies, it's case conferences, it's multi-disciplinary team meetings. This is all work-based learning".' (R1)*

Even when teachers thought that learning opportunities were obvious, this view was not necessarily shared by learners.

'We had a lot of feedback from our junior doctors that they… didn't feel that they were having teaching… The teaching was happening every day [at ward round], but actually the junior doctors weren't seeing or weren't actually acknowledging that that was teaching. So… at the end of the ward round… the consultants would very clearly indicate by always gesturing with their hands "teaching time".' (R4)

Learning opportunities arising during routine work tended to go unrecognised by nurses too.

'Sometimes nurses don't see that they're learning, teaching even, or learning with each other in practice, they just see it as a day-to-day job…' (R3)

This lack of recognition had various consequences for educators in practice. One was that the current expansion of WBL might trouble them as something requiring new skills, whereas in fact they already possessed the skills needed.

'I do think we've got so much good practice that's going on around work-based learning… I think a lot of people don't acknowledge that they're already doing it… We've been doing it for years… This is actually something that we are skilled at doing.' (R4)

Nevertheless, some staff need help to identify how they could facilitate WBL 'on the job'.

'Whether that be face to face, whether that be at the bedside, whether that be a two minute discussion in the sluice, or a two minute education whilst you're making a bed, all of that is valuable learning experience... Things like safety huddles… taking two minutes out of that huddle to give a little educational component to it in relation to one of the patients who is being discussed.' (R4)

Many spoke of the need to increase staff awareness of how to notice and to take opportunities:

'Every room is a classroom, you teach whatever you're doing wherever you're doing it.' (R5)

One respondent gave examples of how she helps staff to see and use opportunities for WBL.

'I developed a session for all our healthcare assistants on supporting other learners in practice. So I just get them to brainstorm and say, "What do you do in practice?" And they list it all, wash patients, urinalysis, bringing patients to and from different places, helping patients… I said, "If I was a first year student and I could learn all of that in my first placement, I would be thrilled"… (R3)

She also illustrated what she might say to a member of staff who needed help in this respect:

'Say you're going in to wash a patient and you're setting up everything… Talk to the student… "Right, let's think about the skin integrity when you're washing the patient, let's think about infection control, let's think about dignity"… and you just get the student to think about that even before you do the task…' (R3)

She summarised thus:

'A lot of the time it's about teaching staff how to question people, and how to do things on the move.' (R3)

It was also important to help learners understand when 'on the job' learning had taken place.

'"I'm not quite sure why doctor wants that test so I'm going to ask him." The key is getting them to realise that that answer is their learning. So, if I say to him, "Why are you doing that?", and he tells me, that's learning. And that's what people don't realise.' (R2)

'You say, "Well, what did you do today?" They're like, "I did this, I did this skill, I gave an injection, I did NG, I took out an NG, I put an NG down." "So you learnt. And did your mentor, was your mentor with you?" "Yes." "Did you talk you through it?" "Yes." "So you had your learning experience." "Oh yeah, I did."' (R3)

Whilst WBL was understood to be present in many settings, characteristics of the learning environment were also identified as impacting on the effectiveness of the learning. These characteristics are discussed under the sub theme headings of: clinical immersion and authenticity and impact on patient and practitioner.

Clinical Immersion and Authenticity

Respondents valued how embedded WBL is in the daily practice of patient care. Firstly, this saved disruption, both physical and mental.

'You're doing it whilst you're working so it's seamless, so you're not having to go off the ward, you're not having to travel anywhere else … You don't have to put a different head on to do it.' (R1)

Secondly, the embedding of learning in practice was thought to facilitate better learning:

'I think students learn far better when they're actually engaged in learning by doing, by seeing, by interacting with others… I think that's one of the benefits of work based learning is that actually they're immersed in it all the time, so rather than us teaching

the theory and then they go away and think about it and then try and put it into practice, they're actually involved in that pretty much all the way through.' (R7)

Thirdly, some opportunities for learning could only arise in clinical practice:

'I've been in a cardiac arrest saying to the student nurse… "You can do some chest compressions"… We didn't save the patient… I brought the student nurse to the side afterwards on her own and I just said, "Look, I'm really sorry if I threw you in at the deep end"… and she went, "Don't get me wrong, I'm really sad that he died. But thank you for giving me that opportunity to get involved in that level."' (R8)

Impact on patient and practitioner

From the learner perspective, it was helpful when colleagues were teaching each other. R9, talking of her supervisor on her nurse prescribing course, said:

'I have worked with that particular doctor for eight years now and we have a very good working relationship… I don't have to cover old ground to prove that I can do this, that or the other because she already knows that I can… I think we're more relaxed together as well.' (R9)

However, this could also be a disadvantage: relaxation may restrict rigour in the supervision relationship. One felt that, as a learner, her own WBL had been slightly limited by her knowing her supervisor very well; she felt they should have challenged her more than they did:

'*I sometimes think that that familiarity leads them to be quite comfortable with what you're doing' (R8)*

WBL was not without challenges, however; first, unsurprisingly, was the pressure of other work:

> *'People just are so overloaded… Your vision becomes really narrow: "I've just got to do this task"… There is no capacity to take on any more, people have run out of energy… You just don't have the head space.' (R1)*

For example, one reported how difficult it was to arrange time with her supervisor to discuss her own learning. She recognised that having learners working with you does increase a supervisor's workload and the time required, for example, to run a clinic. Others described the reluctance among staff to take on supervision or mentorship because of workload.

Secondly, there could be a lack of appropriate skill among staff to facilitate learning less formally.

> *'There's loads of people who think they know how to run teaching and run development programmes. The reality is they know how to put on a show, they know how to do some training. But they don't necessarily know how to enable people to learn.' (R6)*

Thirdly, particular teams might be a barrier to learning if the leadership was defensive. One team was described that was

> *'very focussed on the consultant's perspective… There's this mentality of knowing that their practice could be better but the medics are defending it.… It totally stifles learning.' (R6)*

Fourthly, students themselves might resist WBL. This was often because of their previous experience of learning. One described how students are

> *'now taught [in schools] to pass exams… It's not necessarily, "We have to teach you how to learn", it's "We have to teach you to pass this exam".' (R7)*

The result was that some students dislike the model of student-driven learning:

> *'We give them direction in where to go and find evidence, we work with them to develop an audit of their practice to prove that they're competent, or if they're not competent what they need to do to get to that point. But some of them do still like hand-holding.' (R7)*

The continuity between learning and working helped underline the core purposes and values of learning: high quality patient care.

> *'Work-based learning is about the work we are doing on a day to day basis, and how we share and learn from that. And that is about delivering patient care. So it is more directly related to the end result, the outcome, which is about high quality, best evidence based service for patients.' (R1)*

One respondent contrasted a curriculum that focused on the completion of designated tasks with one that

> *'says learning's really important, and the patient's at the centre: "Think about the patient first".' (R6)*

<u>What makes for success?</u>

Respondents were asked to talk about successful WBL. They highlighted leadership, team commitment to learning and teaching, team dynamics, and good links between education provider and the clinical setting.

Leadership

This was considered important at all levels. One person stressed the importance of leadership at the top of the organisation.

> *'I think a culture of learning comes from the top… We've got a student on our nursing and midwifery board, so they obviously value student input... We have student involvement, student engagement.' (R3)*

But she also went on to discuss leadership at team level:

> *'Definitely the ward manager, the ward sister, charge nurse, and their engagement in education [are important]… They [good ones] are like really enthusiastic, they take students all the time, they don't think about [how] they've got an extra student, they're not worried by this. Everybody's engaged in [education] from the healthcare assistant [upward].' (R3)*

Another gave an example of how good leadership had transformed a ward's attitude to providing a learning environment.

> *'They've used work-based learning, which has been led by the ward manager in actual fact, who's brought in the practice development folk… But that's been very much around the ward manager role-modelling that this is important and being quite humble, but also reaching out to a whole range of education and practice development support.' (R6)*

This ward manager had linked the ward's WBL agenda to individual goals as identified in their appraisals.

Another saw inspirational and affirmative leadership as helping to create a good learning environment:

> *'If you inspire your staff or celebrate their successes, you begin to change the culture to one that's more responsive to learning and one that's not so rigid and tight.' (R1)*

Team Commitment to learning and teaching

Where this was evident staff and learners acknowledged their need to ask questions and to seek guidance.

> *'You've got to have that open forum that if someone doesn't know, they can stick their head through the door and [ask]… Everyone's comfortable coming to me or to [X], or to each other, and I think that's important. '(R5)*

One respondent felt that the size and function of the team could affect its attitudes.

> *'A&E are very good at doing training…They're a very defined, tightly knit, cohesive group of staff… They're very proactive and they take responsibility for their training… If you put more than one ward together the focus becomes disparate, because they all have different clinical responsibilities, so you haven't got the critical mass that you need really.' (R1)*

While another had observed that the excitement and pace in an area affected both staff and learner

'Trauma is seen as a very fast paced, sexy environment to work in, everyone loves trauma…a lot of students would be very excited to be working on the trauma ward and I had a very young enthusiastic team around me who wanted to show their student nurses, this is a chest drain, this is how we look after it….'(R8)

Team dynamics

It was hard to provide a good environment for WBL when a team's dynamics was unhappy or dysfunctional:

'If you've got a team that's arguing, scrapping, not well led, there isn't that opportunity, there isn't that engagement.' (R5)

Links between the education provider and clinical setting

Some emphasised the view that good links between the education provider and the clinical setting were crucial. One described how wards that were considered poor learning environments by learners were often open to change in this respect once they had feedback about how they were experienced.

'I said, there's inconsistent feedback from students. They were upset by that … Since then, they've got a little bit more engaged, and the student experience has been better.' (R3)

Figure 1: Diagram of themes

Discussion

Given the increase in WBL across healthcare settings, it is crucial to understand relevant success factors. Nine professionals with an interest in WBL were interviewed, and transcripts analysed thematically. The findings suggest the importance of a strong learning culture in the clinical environment, time and commitment to facilitate WBL, and identification of learning opportunities to be essential.

An effective learning culture

The organisation

Respondents identified the importance of their organisation being prepared to support WBL. This is congruent with literature such as Flanagan et al. (2000). Such support includes a range of activities. Rose et al (2001), writing of off-campus learning in general, suggest that 'the employer would usually appoint a member of the HR/training department who can 'co-ordinate staff, resources, rooms, calendars, and records, including keeping copies of all documentation that flows between the student and the university'. Clearly, all these functions need to be allocated and carried out, though it may not be usual in NHS organisations to make a single person responsible for all of them. The complexity of healthcare organisations may militate against the establishment of WBL unless there are strong systems in place to support it (Govranos and Newton, 2014).

The respondents linked a positive culture of learning with the support provided by local managers, including their function as role-models. This view is supported by Kemp et al's (2016) study, which found varying commitment among ward managers, who determine the extent to which learning is prioritised on their wards. Poor interpersonal relationships in a clinical area were also thought to militate against effective learning in our study, and this is supported by Nevalainen et al (2018): 'good interpersonal relationships between staff and the ability to cooperate in utilising knowledge and expertise in the work community create a positive learning culture' (p 27).

Time and commitment to facilitate learning

Respondents identified the perceived 'overloading' of clinical staff as a major barrier to the success of WBL; both in finding staff to undertake and carry out supervision. Eraut (2004) also demonstrated the importance of the workplace to the success of WBL, with allocation of work, social climate and personalities playing important roles in enabling or constraining the process. The 'culture of busyness' in healthcare described by Nevalainen et al (2018; p26) may not be conducive to learning, with the tension between demands for effectiveness and staff development being described as part of the 'essential paradox of work-based learning' (Nevalainen et al, 2018: p27). However the participants identified that WBL can be undertaken in parallel with clinical roles, and that busy places can offer good learning experiences, suggesting that some clinicians are able to embrace learners in their practice, and perhaps even welcome them. A report by the Royal College of Physicians, entitled '*Never too busy to learn'* (Basheer et al, 2018), embraces this approach, acknowledging the 'concerns raised about tensions between service delivery and education/practice

development' (p.1), whilst offering practical suggestions to maximize learning in the workplace.

However, similarly to the views expressed in Attenborough, Knight and Brook (2018), the participants did identify constraints involving time. Baxter et al (2009) emphasise the balancing of roles required of nurse educators with diverse responsibilities to patients, colleagues and the organisation. Omansky (2005) identifies not only intrinsic rewards in carrying out the education role, but also work overload, and role conflict. Chapman (2006) notes that reports of insufficient time for supporting WBL highlights the difficulty of fostering a work environment conducive to learning in an already stretched workplace, a recurrent theme in our study.

Identification of learning opportunities

Learners

Respondents reported a need to explicitly identify and recognise learning opportunities. Some, such as ward rounds or Schwartz rounds, where reflection rather than direct skills-teaching is the learning method, required more sign-posting by supervisors. There is wide agreement in the literature that while opportunities for learning in the workplace are in theory abundant, in practice these opportunities may not be taken. This may be because learners are shy and anxious, which inhibits them from identifying and taking such opportunities (Jedaar et al, 2009). Learners may also be unable to focus on their own learning because they are being given tasks to complete or feel obliged to assist colleagues (Kemp et al, 2016).

The ability of learners to identify opportunities is reported to be more advanced in learners with an already established role in practice (Ramage, 2013); this is a hopeful finding given that apprentices in healthcare are generally drawn from the existing workforce.

Supervisors and mentors

Techniques for ensuring identification of opportunities were described by respondents as the responsibility of the supervisor or mentor. Wareing (2015) emphasises that learners must participate in the full range of work in order to derive sufficient breadth of learning from their experience. While every situation is a potential learning situation, we do not necessarily learn from everything we do, and it is therefore the supervisor's responsibility to ensure that real learning is extracted from a learners' activities. The environment may limit what the supervisor can do in this respect. For example, no-one can predict clinical events and ensure that learners can witness or engage with them (Jedaar et al, 2009). Our study demonstrates that engaging a learner in an unpredicted situation such as resuscitation presents the opportunity for learning on many levels.

Jedaar et al (2009) also point out that case-mix may limit learning opportunities, as may a reluctance on the part of patients to be part of a learning/teaching episode.

The participants reported challenges about learning experiences and expectations of students; Baxter et al (2009) suggest that WBL teachers need to learn how to encourage an active learning style, engage learners in problem-solving, and enhance learners' skills of enquiry. In this way, responsibility for identifying and taking opportunities for learning must be shared by supervisor and learner. It is important that learners can question what they see, as staff whose competence in particular skills is limited cannot be effective role models

(Kemp et al, 2016). Furthermore, the participants identified some of the challenges and advantages of being supervised and assessed by those who are long-standing colleagues, which may lack robustness or conversely be based on mutual understanding and respect.

Supervisors need to learn how to make what they do explicit to learners (Phillips, 2012), as one of the participants described consultants having had to learn to do at ward round. Often activities seem to be routine or intuitive to those performing them, and they may therefore not find it easy to explain them clearly to learners. It is also essential (Phillips, 2012) that learners are taught how to reflect on their experience, as the link between theory and practice is not always easily bridged, and students may, for example, find it difficult to identify the key points for analysis from an incident that they witness.

Limitations and recommendations for future research

Whilst nine participants were interviewed, the sampling methods were adjusted in the early stages of the study. The original intention was to recruit individuals from a Community of Practice involved in the delivery of WBL, but due to time constraints and clinical commitments, most were not able to be interviewed. It is notable that these are some of the same constraints identified as barriers to WBL itself. The snowballing method recruited another four participants, but by the very nature of snowballing these participants were also WBL enthusiasts. Thus, our sample selection, combined with our focus on success factors for WBL, may have led to an overly positive view of WBL. However, whilst future research should aim to include those who are less positive about WBL, it is evident in our results that even the enthusiasts we interviewed were forthcoming in explaining the barriers and drawbacks of WBL, even when they were not explicitly asked to do so. In particular, participants spoke about how the identification of supervisors and assessors in practice can

give rise to conflicts of interest. Further research should address the relationship between supervisor and learner in WBL, where long-established friendships may become challenged or the robustness of assessment and supervision questioned.

Given that respondents identified both time and capacity as important resources to enable WBL, yet two of the busiest settings were recognised as more effective learning environments, further research is needed to explore how such settings are able to overcome these universal challenges.

As we targeted those delivering WBL, the voice of the learners is somewhat absent from our findings. However, as some of the participants were additionally recent graduates of WBL experiences, these individuals were able to reflect on WBL from the position of both learner and educator. Nevertheless, further research is necessary to understand the experience of learners training for new roles such as the Nursing Associate where the role is not yet fully established in practice and regulation is only recently confirmed.

Conclusion

The findings of this study have immediate relevance for healthcare systems globally. The study participants identified several opportunities and threats in the clinical environment to the establishment and supervision of WBL, recognising the importance of identification of learning opportunities, time and resources to implement WBL and leadership with commitment to WBL. The scope of possibilities for learning in practice is abundant but requires courage and commitment from both learner and supervisor. The current healthcare workforce shortage internationally makes WBL especially challenging, but

interestingly, A&E and trauma were mentioned by some of the participants as demonstrating commitment to learning and richness of opportunity. Although increased workloads and staff shortages may work against successful WBL, the drivers for both recruitment and education of registrants and retention of staff are rooted in this shortage. Valuing learning, commitment from organisations and identification and signposting of learning opportunities are crucial to its success. As the participants pointed out, these are not unrealistic aims: WBL is already widely practiced across healthcare organisations, though it may not always be recognised or valued as such: everywhere and nowhere.

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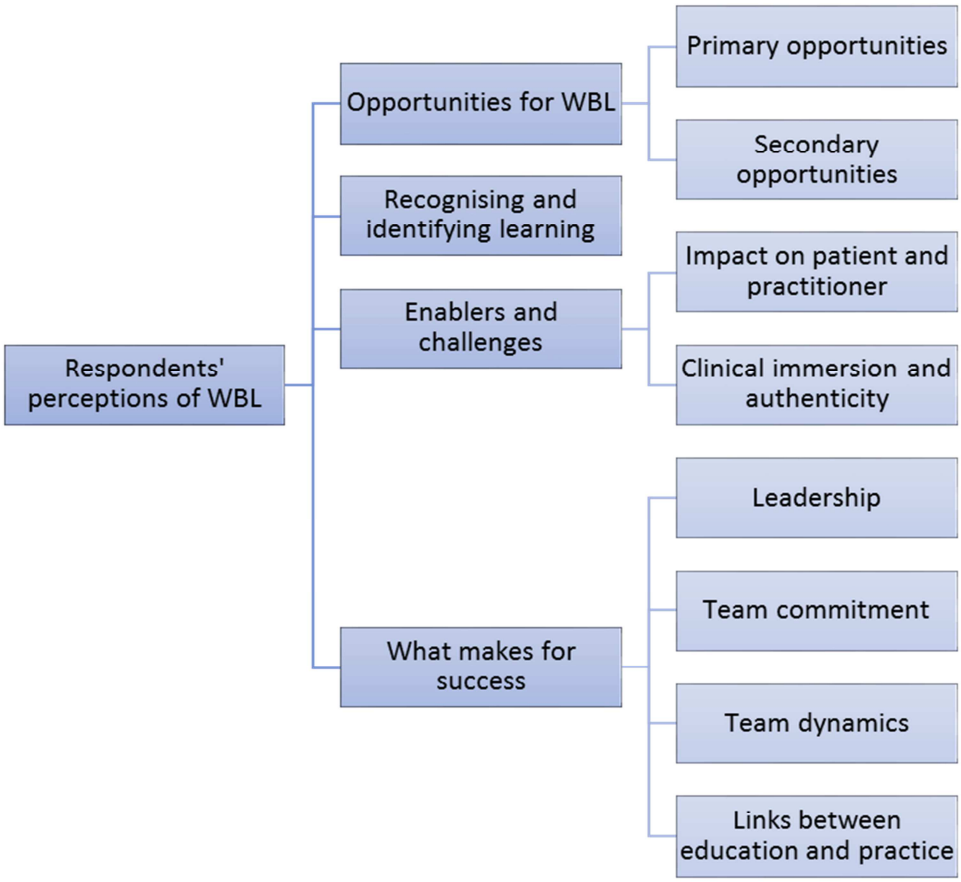
Respondent code	*Role*	*Trust code*
R1	Senior clinical educator	T1
R2	Senior clinical educator	T1
R3	Senior nurse educator	T2
R4	Senior nurse manager	T3
R5	Nurse consultant	T1
R6	Senior nurse manager	T4
R7	Senior University Teacher	Provides clinical teaching in practice
R8	Clinical nurse specialist	T4
R9	Clinical nurse specialist	T1

Figure 1: Diagram of themes



Highlights

- Clinical practice is a rich learning environment
- Learning opportunities are not always identified in clinical practice
- Increased workloads and staff shortages may militate against effective work-based learning
- Supportive leadership, time and commitment are essential to the success of work-based learning
- Demanding areas such as A&E and trauma can provide effective work-based learning

Conflict of Interest Statement

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Ethical approval
Ethical approval was granted by the School of Health Sciences Ethics Committee, City, University of London. All respondents completed a consent form.